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BEFORE THE
BOARD OF VOCATIONAL NURSING AND PSYCHIATRIC TECHNICIANS
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **LA MOINE EDWARD DAVIS** **1482 E. Padua Way** **Palm Springs, CA 92262** **Vocational Nurse License No. VN 44498** Respondent.	Case No. VN-2009-114 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Teresa Bello-Jones, J.D., M.S.N., R.N. (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Vocational Nursing and Psychiatric Technicians, Department of Consumer Affairs.

2. On or about December 21, 1970, the Board of Vocational Nursing and Psychiatric Technicians issued Vocational Nurse License Number VN 44498 to La Moine Edward Davis (Respondent). The Vocational Nurse License will expire on February 28, 2013, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board of Vocational Nursing and Psychiatric Technicians (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2875 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline the holder of a vocational nurse license for any reason provided in Article 3 (commencing with section 2875) of the Vocational Nursing Practice Act.

5. Section 118, subdivision (b) of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated. Under section 2892.1 of the Code, the Board may renew an expired license at any time within four years after the expiration.

STATUTORY PROVISIONS

6. Section 2878 of the Code states:

> The Board may suspend or revoke a license issued under this chapter [the Vocational Nursing Practice Act (Bus. & Prof. Code, 2840, et seq.)] for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual nursing functions.
>
> . . . .
>
> (j) The commission of any act involving dishonesty, when that action is related to the duties and functions of the licensee. . . .

7. Section 2878.5 of the Code states:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Vocational Nursing Practice Act] it is unprofessional conduct for a person licensed under this chapter to do any of the following:
>
> . . . .
>
> (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to narcotics or dangerous drugs as specified in subdivision (b).

REGULATORY PROVISIONS

8. California Code of Regulations, title 16, section 2520 states:

> As set forth in Section 2878 of the Code, incompetence is deemed unprofessional conduct and is a ground for disciplinary action. As used in Section 2878 "incompetence" means the lack of possession of and the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by responsible licensed vocational nurses.

COSTS

9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FACTUAL ALLEGATIONS

10. Respondent was employed as a licensed vocational nurse by Palm Springs Health Care (PSHC), a skilled nursing facility. On or about July 13, 2009, the Board received a complaint against Respondent, filed by PSHC, alleging that Respondent falsified a Controlled Count Sheet. As a result of the complaint, the Division of Investigation (DOI) conducted an investigation into the allegations. The report revealed the following:

11. PSHC policy required that during a shift change, the oncoming nurse must conduct a reconciliation by performing a physical count of the remaining medication by two persons who are legally authorized to administer medications. On or about June 15, 2009, Respondent was relieved by the oncoming LVN at approximately 2300 hours. As reported by Respondent's relief, the Controlled Drugs-Count Record did not reflect that a reconciliation/inventory was conducted when Respondent started his shift at 1500 hours. Respondent refused to conduct a physical inventory but then signed the Controlled Drugs-Count Record, in the presence of his relief, as though he had conducted the inventory at the beginning of his shift. Respondent later admitted to the PSHC Director of Nursing that he failed to conduct a controlled substance inventory when he came on duty.

12. On or about June 16, 2009, two cups containing medications were found in the top drawer of the medication cart after Respondent had clocked out. The medications were traced to

a patient who was supposed to receive the dosage at 0630 hours. The medications were recorded administered by Respondent. Respondent failed to administer the medications to the patient as ordered, and failed to alert his relief that his patient missed their 0630 dosage. On June 16, 2009, Respondent received an Initial Written Warning regarding the above incidents.

13. On June 12, 2009, a patient received a shipment of two boxes of fentanyl transdermal patches,[1] containing five patches in each box, for a total of ten patches. Respondent erroneously believed there was supposed to be ten patches per box, for total of 20 patches. During the shift-to-shift narcotics count on June 16, 2009, at approximately 0730 hours, it was discovered that Respondent had falsified the patient's Controlled Drug Record by making entries for June 1, 2009, June 3, 2009, June 6, 2009, June 9, 2009, and June 12, 2009, forging dates and signatures of other nurses, indicating that the patches were administered to the patient. Respondent admitted that he forged the entries because he believed there were fentanyl patches missing and he wanted to make the medication count correct. The patient was not admitted to PSHC until June 5, 2009.

14. On June 16, 2009, Respondent received a Final Written Warning and he was suspended. Respondent's employment with PSHC was subsequently terminated.

FIRST CAUSE FOR DISCIPLINE

(Incompetence)

15. Respondent has subjected his license to disciplinary action for unprofessional conduct under section 2878, subdivision (a)(1) in that he was incompetent, as defined by California Code of Regulations, title 16, section 2520, in that on or about and between June 1, 2009 and June 16, 2009, while employed by PSHC (as detailed in paragraphs 10-14, above), Respondent failed to properly document his handling of controlled substances in the hospital's medical records. Respondent's actions demonstrated a lack of possession of and the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a responsible licensed vocational nurse.

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[1] Fentanyl, sold under the brand name Duragesic, is a Schedule II controlled substance as designated by Health and Safety Code Section 11055, subdivision (c)(8), and is a dangerous drug pursuant to Business and Professions Code section 4022.

SECOND CAUSE FOR DISCIPLINE

(Dishonesty)

16. Respondent has subjected his license to disciplinary action under section 2878, subdivision (j) of the Code for unprofessional conduct in that on or about and between June 1, 2009 and June 16, 2009, as described in paragraphs 10-14, above, Respondent committed acts involving dishonesty when he intentionally made falsified entries in hospital records.

THIRD CAUSE FOR DISCIPLINE

(Fraudulent Documentation in Hospital Records)

17. Respondent has subjected his license to disciplinary action under section 2878.5, subdivision (e) of the Code for unprofessional conduct in that on or about and between June 1, 2009 and June 16, 2009, as described in paragraphs 10-14, above, Respondent made fraudulent entries in hospital and patient records pertaining to controlled substances prescribed to patients.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Vocational Nursing and Psychiatric Technicians issue a decision:

1. Revoking or suspending Vocational Nurse License Number VN 44498, issued to La Moine Edward Davis;

2. Ordering La Moine Edward Davis to pay the Board of Vocational Nursing and Psychiatric Technicians the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: June 23, 2011

TERESA BELLO-JONES, J.D., M.S.N., R.N.
Executive Officer
Board of Vocational Nursing and Psychiatric Technicians
Department of Consumer Affairs
State of California
Complainant

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